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Homecare services in one local authority: client and provider views

Jennifer Francis and Ann Netten

PSSRU Discussion Paper 1795/3
October 2002

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Jennifer Francis and Ann Netten

Discussion Paper 1795/3
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¹ The authors respect the authority's wish to remain anonymous

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Summary

1. This paper reports on the findings of a small-scale study that investigated the meaning and delivery of quality in home care in one Local Authority from the perspective of users and providers and explored the views of users about proposed changes in the authority's approach to commissioning.
2. Twenty users and 12 providers were interviewed about their experiences and attitudes to quality in home care. Users were receiving services from seven of the providers interviewed. Although the samples were small, users and providers reflected a wide range of circumstances. Users were mostly receiving high levels of homecare, and had usually been receiving services for several years.
3. There was some evidence of discrepancies between the activities undertaken and reported care plan (based on the user's perspective). Four users had domestic tasks, meals prepared or shopping undertaken outside the commissioned hours. Home carers undertook this in their own time.
4. Of the seven key aspects of quality; staff attitudes, reliability, and flexibility were of key concern to service users, identified most frequently when first asked about the aspects of service quality that was important to them.
5. With few exceptions users were very happy with the attitudes of their carers. The three attitudes most commonly cited as important were being 'obliging', 'friendly', and 'understanding'. Other common views were that carers should be cheerful and that they should treat people with respect.
6. Timing of visits and reliability were crucial aspects of quality for about half the users interviewed. It was the tasks to be undertaken together with the attitudes of the individual user that determine the importance of timing and reliability. Providers tended to rate their performance in the areas of reliability and communication rather higher than would be expected given the views of the users of their services.

7. Experience of flexibility of the home care service tended to be very much at the level of the individual carer and her attitude to the rules and doing tasks in her own time, resulting in inequitable service receipt by service users and, arguably, exploitation of home carers. Providers saw themselves as tied into the care plan so having little scope to offer a flexible service. This arrangement results in inequity where those who feel unable to ask for changes and those with uncooperative home carers receive less than those where the carer helps out over and above the official hours.
8. Although users tended to prefer having the same home carers, the issue of continuity was only of critical importance for a few. This was linked to their particular circumstances and to issues of trust and communication.
9. Communication was an important issue to many of the service users and it was intrinsically linked to both reliability and continuity. Although most users felt they were kept informed this was often through the home carers rather than the organization, which users often felt was inappropriate. This was particularly important for those very dependent on the service.
10. Skills and knowledge was linked to the characteristics of the home carer in most users' minds: their age and gender and above all their motivation. Providers were primarily concerned with the cost and practical implications of meeting the new Care Standards, particularly the training requirements.
11. With a couple of exceptions (based on bad experiences) users felt their home carers were trustworthy. They primarily defined this in terms of honesty rather than confidentiality. There was some evidence that some home carers were not keeping the confidences of service users.
12. Whatever commissioning and contractual arrangements are put in place to allow more flexibility on the part of the provider, there will always be tasks (such as certain domestic tasks and shopping) that it is not intended for the contract to cover. If problems of inequity and the potential for exploitation are not to persist, the local authority has to be clear how these needs are to be met where informal sources of assistance do not exist. Clarity is needed at all levels both about who provides and who meets the cost.

13. There is clearly a lot of time pressure under the existing arrangements. Any arrangement that allows capacity for carers to spend time encouraging people to do things for themselves will need to compete with pressure from users to get other tasks done, including those tasks not officially part of their care package.

14. Users varied in their opinions about commissioning arrangements but were generally informed by their view of which party was best placed to make decisions about their needs. However, whatever their views service users generally wanted their care manager to be able to uphold their interests and intervene whenever they experienced problems with their care package.

15. Providers would welcome a more active role in managing the care arrangements, and this would address some of their concerns over providing a flexible service. However, there are concerns about whether the prices paid will cover all the costs that they are likely to incur if they are going to recruit and retain a well-motivated and skilled workforce. This is not just about the price it is also about expectations. With the dominant type of contract, spot or call-off, the provider bears all the risk. In such situations expectations are key to planning and ultimately service quality.

1. Background

An important issue for commissioners, providers and evaluators is the identification of the quality of services from the user perspective. In preparation for re-letting home care contracts the local authority wanted to consult service users and their carers to establish their perceptions about, and the aspects they most value of home care services. This paper reports on the findings of a small-scale study that investigated the meaning and delivery of quality in home care in one local authority from the perspective of users and providers. It also explored the views of users about proposed changes in the authority's approach to commissioning.

We start by outlining the method used and we then describe the characteristics of the consulted provider agencies and the characteristics and needs of the service users. Section 5 reports users' experience of the home care service and section 6 the important aspects of quality from the perspective of users and providers. Finally, the report addresses the future developments of home care provision in the local authority and highlights the views of service users and home care organisers on those proposals for change.

2. Method

From a list of 19 provider agencies in the local authority, 12 were randomly sampled and the managers agreed to be consulted. After two pilot interviews, slight changes were made to the interview schedule for the remaining 10. The interviews were in depth and face to face and with the exception of one, they were tape-recorded. The exception was one manager who did not want her views recorded despite assurances of complete confidentiality.

A previous round of service user consultation, via the Higher Standards questionnaires completed in the authority in March 2002 meant the council was able to identify 50 older people who, in the previous consultation, had agreed to be contacted again in future to give their views on quality issues. Ten out of the fifty service users were initially approached for the pilot stage and six were interviewed.

Following the pilot stage and consequent revisions to the interview schedule, a further 23 service users were approached and 14 were interviewed. In total 33 were approached and 20

interviews undertaken with service users and in some cases, their carers, a 61 per cent response rate.

As with the provider interviews, all service user interviews were in depth, face to face and all were tape-recorded. Once offered assurances that neither their carers, home care managers nor care managers would find out their views, all service users were happy to have the interviews recorded.

3. Characteristics of providers

Seven of the 12 home care providers were private, for profit organisations and five were voluntary and/ or charity organisations. One provider was specifically a carer's organisation.

The size of the provider organisations varied widely in terms of numbers of full and part time care staff, number of care hours provided in an average week and the geographical extent of their businesses.

Five domiciliary providers employed less than 50 care staff, four employed between 50 and 100 carers and three employed over 100 carers, the biggest of which employed over 300 care staff. In terms of average weekly care hours, six organisations reportedly provided 1,000 hours or more, five provided 500 to 1,000 hours and only one provided less than 500 care hours per week. The geographical extent of the providers varied but over half covered the whole of the study authority plus part of at least one other neighbouring authority. Two covered the whole of the study authority and no other authority and three covered just part of the study authority.

While agencies' capacity varied significantly, the tasks that they carried out and the aspects of home care they delivered were more consistent. All except one agency provided domestic help, meal preparation, laundry and personal care. The exception was the carer's organisation that concentrated on personal care and medication calls. All except two agencies provided bathing calls and those that didn't were part of a larger organisation in which there was a specific bathing service that would be separately commissioned. Three providers specified that bathing would only be provided following the satisfactory completion of a risk assessment exercise on an individual case basis. Sitting and night sitting

calls were also commonly available. Two thirds of the agencies reported being able to deliver those aspects of care but about half of those currently had no social services contracts to provide them. Only two out of the 12 organisations reported providing shopping either with or for their clients. Both were private providers.

The tasks highlighted above are those that were most commonly provided in the local authority. However, there are a range of other tasks including respite, befriending, help to hospital appointments, advocacy, hairdressing, chiropody, 'put to beds', wake up calls, check up calls and emergency telephone systems which were variously provided, especially where large organisations encompassed separate agencies that deliver those activities.

4. Characteristics of service users

Twenty service users were interviewed during the consultation process. The group consisted of ten men and ten women. Twelve were over 75 years old at the time of interview, with six 85 years or older. Every person interviewed described their ethnic origin as white, British.

The majority of those interviewed lived in a single person household, only five were married and lived with their spouse at home. One service user who was married and lived with his wife also had one daughter who remained living at home with them.

With the exception of only one person, most of those living alone enjoyed some form of social contact from a friend, neighbour or family member. For almost half, that contact was on a daily basis and only two people enjoyed social contact less than once weekly. All service users living with their spouse had regular social contact from family members, neighbours or friends.

Sixteen of the respondents used formal support services other than home care. These included regular treatment from a district nurse, attendance at a day centre and, in only one case the receipt of a 'meals on wheels' service. The person receiving meals on wheels lived alone.

The frequency of visits and treatment by the district nurse varied greatly but the most common situation was to see them between once a week and once a month. Only one person

saw their district nurse more than once a week. That service user, was over 85 years of age, lived alone and had chronic health problems. Almost half the group as a whole either never saw a district nurse or saw one only when necessary.

Take up of day care was very low. Only six of the entire group attended a day centre, one of those was only on a monthly basis. Most of those who attended were from single person households; only two people living with their spouse reported visiting a day centre at all and in both situations the motivation was for respite for the husband or wife. Negative attitudes about the concept or image of day care were pervasive and illustrated by one service user who, although she recognised her old age and frailty was adamant she wouldn't like to attend a day centre " wouldn't like to go and sit down among all those old people...I don't know why I call them old, I'm old...I just don't feel old."

Areas of concern about service provision other than home care focused on gardening and aids and adaptations. Two service users lamented the fact that they could no longer keep their gardens looking "nice" and had no one who would do it for them. One service user, who was visually impaired, was simply waiting for someone to paint two white stripes along the edge of his garden step. Another had applied to social services 5 months previously to have a shower installed, as without it she was unable to wash properly. Frustrated at the lack of communication and activity on the part of social services she exclaimed, "I think it's (the shower) still in China!"

5. Receipt of home care

Out of the authority's 17 contracted providers, the service users that were interviewed represented eight, but possibly more as two people did not know the name of their provider agency. Seven of the provider organisations being used were among the 12 providers interviewed during the consultation process.

Twelve of all those interviewed had begun receiving home care following hospital discharge. Another six began when their health had deteriorated and the remaining two cases had been due to a fall or illness and, the reduction or withdrawal of informal care.

Although the time that people had been receiving home care varied, a majority, nearly two thirds, had been receiving it for between one and four years. A quarter of the group had been receiving home care for five years or more and two people had had home care support for 10 years or more. Only two people were relatively new service users and had been receiving it for between six months and a year.

For the most part service users were receiving high levels of home care input. Seventeen out of the 20 service users received the service every day of the week. One person received visits six days per week, one had care twice weekly and a third person was just visited weekly. The least amount of care hours provided per week was one and a half and the most was 17 and a half hours. On average, the 20 service users interviewed in the study authority received 8.5 hours of home care per week. This compares with a national average of 7.6 hours per week. (Department of Health, 2001).

Table 1 shows the types of help that people received from their home care organisation and other sources. In some instances people received help from more than one source. The most frequently commissioned task was personal care. Nearly two thirds of those interviewed received help with personal care and none of the remaining seven reported that ‘personal care’ was an unmet need.

Table 1: Types and sources of help (number of cases)

	<i>Home care</i>		<i>Informal care</i>
	<i>Formal arrangement</i>	<i>Informal arrangement</i>	
Personal care	13	0	3
Domestic tasks	10	2	8
Meals preparation ¹	11 ²	1	5
Shopping	3	1	14

Notes:

1. Excludes one person who was receiving meals on wheels.
2. Includes one person who was not sure whether this was a formal or informal arrangement.

Half of those interviewed reported receiving domestic help as agreed in their care plan. A further two people reported having domestic help that had been informally arranged with their home carer. The remaining eight service users reported having no need for domestic help; five because they had help from their spouse, one because they had informal help and two because they could manage alone.

Meal preparation was delivered to 12 of the 20 service users. Ten said that it had been agreed in their original care plan, a further person had an informal arrangement with their carer and another individual received help with meal preparation but didn't know whether it was a formal or informal arrangement.

Tasks that were less commonly delivered were shopping and errands and medication calls including dressings and medication prompts. Four of those interviewed had help from home carers with shopping and other errands. Three identified this as part of the formal care plan and one through an informal arrangement. The other 16 service users said they had no additional need for help with shopping; two because their spouse was capable of doing the household shopping and errands, 11 because a friend or other family member did their shopping either with or for them and three could reportedly manage alone. There was a similar situation with medication calls as only three of those interviewed said they needed help and they all received it. The rest of those interviewed received help with dressings from their district nurse or spouse.

The interviews also gathered information about the changing nature of people's care plans over the period they have been in receipt of home care. Over half of the service users had experienced no change in the level of care they received, as there had been no change in their own health or mobility or in the health or mobility of their spouse. Thirty per cent of those interviewed reported that their care package had been increased since it's inception and in each case, they put this down to their own deteriorating health and/ or mobility. Most of those people had been receiving home care for five years or longer. Finally, three of those interviewed reported having less care than when they first started receiving home care. In all three cases this was because they had got stronger or improved and no longer needed as much help.

6. Quality of service

Before exploring specific quality characteristics, the interviews gave service users the chance to raise aspects of their home care that they particularly valued or points that they saw as being problematic. Those interviewed after the pilot stage were also asked to assess the overall quality of their home care. Out of those 14, 12 felt they received a good quality service, one person felt they did not and one other judged their service as “fair”.

The issues that people volunteered initially as positive aspects of their home care were principally around the attitudes of their carers and their willingness to help and do jobs beyond those stipulated on the care plan. Thirteen of the 20 interviewed positively identified attitudes of their carers. They valued cheerfulness, friendliness, understanding and an instinctive caring nature. Only one person cited staff attitudes as a problem of their home care service, “they should treat me with more respect and shouldn’t be over familiar. I wish they’d draw line with the familiarity. I wish they would show more respect and professionalism”

Eight out of all those interviewed cited flexibility as one of the good aspects of their service. Service users and their families both valued carers willingness to do extra jobs often, without even being asked, “they want to do everything they can for me, they’re very good”. However, not all of those interviewed identified flexibility as a positive aspect of their home care. Two people mentioned it as a problem citing the view that their carers seemed to do the bare minimum, that they were confused about exactly what their carers were allowed to do and that having being turned down in the past, they knew there was little point asking for extra help again.

The reliability of their home care service was something service users also volunteered as being an issue. Opinion was divided. Although six people reported having a reliable service with carers who generally arrived on time, another five raised it as a problematic issue (see section 6.1 below). However, the remaining nine did not mention reliability at all when asked about the good or poor aspects of their service.

Attitudes, reliability and flexibility were aspects of care people most commonly raised. However, they also identified the sense of security provided by their carers' visits, the way care tasks are carried out, the choice of carer and the trustworthiness of their carers.

Following the open-ended discussion service users were invited to consider seven key aspects of quality in more depth.

6.1 Reliability and timing of visits

Users were asked specifically about their views on reliability and the precise timing of visits. Reliability was clearly an important quality characteristic to half of the service users and their informal carers as 10 out of the 20 cited specific reasons why timing was crucial. People emphasized their need to retain control over their daily lives and saw waiting for home carers who never came or arrived late compromising this. "You can control your own life if you know what's going to happen with your day ... There's nothing worse than sitting round all day waiting for someone who should have been there..." Six out of those ten people had specific reasons to want their carer to arrive at a precise time. Reasons given included the routine necessary to manage diabetes, the need for regular and routine meals, and because of the importance of control over their daily lives. Of those six people, only one always received their visit at the time it was expected.

However, time keeping is not important to everyone. Half of those interviewed placed little priority on the actual time they arrived and placed more importance on simply knowing their home carer would arrive at some point in the day, "It doesn't matter, as long as I know they're coming, that's the main thing".

Reliability of the service

Respondents were asked to rate the reliability of the service they received. As table 2 shows, 95 per cent of people said their home carer usually or always arrived when they expected them to.

Table 2: Reliability of the service

	<i>Number</i>	<i>Percent</i>
They <u>always</u> come when I expect them to	4	20
They <u>usually</u> come when I expect them to	15	75
They sometimes come when I expect them to	1	5
They <u>never</u> come when I expect them to	0	0
Total	20	100

This result was somewhat surprising as in the initial discussion about quality five respondents had identified problems with reliability. For example, one service user reported having nine missed calls over the time he's been receiving care. Another service user reported that she'd been left without carers on a number of occasions. She even explained that on those occasions her home care company have told her to find her own carer and she was clearly unhappy with her situation, "By the time you realise nobody's coming, it's too late to phone up...I don't know whether that's the general practice or whether it's just the one company but I feel it's wrong..."

Most of the service users explained that their carers were unable to arrive at the same time due to a range of human circumstances. So for example, "I find that they're a bit anxious to get it done – and that's not altogether their fault, it's because they have so many to get done in one day" and "if the carers are late there's always a human answer for it, like an emergency with the person before or they're stuck in traffic..." Another service user recognised that although her carers were sometimes late, this is due to emergencies with other service users or other human factors, which mean that they can't always arrive on time. The service user felt that it was all about give and take, "when the girls have finished their work I let them leave, 'cause I know they're not allowed travelling time". The issue of travelling time was something many of the service users were aware of and many felt the situation as they saw it was unfair and illogical. More than one person suggested it would make more sense for their carers to work in geographical patches as a way to reduce travelling time between calls and reduce the problems of traffic hold ups between visits.

It is possible that going through this reasoning process meant that when they came to identifying the reliability of their service, respondents were actually judging whether their carers were *reasonably* on time – whether it was excusable that they were often late. So perhaps, “they usually come when I expect them to” was more “they’re rarely on time, but you can’t blame them, it’s not their fault”.

It is of interest to link respondents’ views of the importance of reliability with their experience. Of the 10 who felt timing was unimportant, three always received visits when they expected them and seven usually did. Of the 10 who, for a range of reasons, felt timing was important only one person always received visits when they expected them; eight usually did and one person only sometimes did. This could reflect perceptions – those for whom timing was important being more aware of late arrivals.

The provider perspective

The views of the managers of the provider organisations in the study authority largely matched those of the service users’ views on reliability. Some of the explanations service users gave for their carer’s late arrivals or missed calls were the same as the reasons given by providers for not being able to consistently maintain reliability, “there’s not a lot we can do if a client is ill or has a fall and the carer needs to stay with them longer...” or “traffic – there’s not a lot we can do about that”.

However, there was also the suggestion, by providers, that pressures exerted by social services commissioning arrangements made it very difficult for them to deliver a reliable service. In answer to the question ‘what makes it difficult to provide a reliable service?’ one provider reported,

“It’s partly because of the current task focussed SDO’s² and the current financial constraints that affect local authorities. We’re being paid to do half hour after half hour, one after another. We’re rushing between clients at the moment and have less chance of maintaining reliability...”

² Service Delivery Order

Although the service users didn't make the final link back to the local authority commissioning arrangements they did feel that an unreasonable burden of work fell on their home carer. They felt that their carers had too many visits to make in very little time, over an unreasonable geographical patch and that the outcome was rushed visits and late or even missed calls.

Nevertheless, there was some significant difference in opinion between service users and providers. The difference lay in their views about the providers' level of success in delivering a reliable service with consistently punctual visits and no missed calls. Providers had a much more positive perception of their performance and were confident that they had the organisational mechanisms in place to ensure that reliability is maintained. Those mechanisms included monitoring, supervisions and service user spot checks. They also included the organisation's philosophy and policies and almost all managers reported that the aim to provide a reliable service was central to their work,

“It's the way the organisation has evolved. At the beginning we agreed standards and values and we've made sure that that's been the case the whole way along. New carers are taught our ethos right from the start”.

And another manager claimed “we work very hard to achieve that aspect...it's the management structure in place that makes it possible....and good communication”.

However, service users of the second quoted provider identified poor reliability. One service user counted nine missed calls during the time he'd been receiving care. Another, who had since asked to change her provider company, reported that they “forgot me quite a lot”. That service user had late and even missed calls and had never been warned when her carer was going to be late. Nevertheless, she was much happier with the reliability of the provider she subsequently changed to. The manager of that company felt strongly that:

“The two managers working on that (reliability) aspect of the service are very hot on the moral aspect of the service. As far as they're concerned they work for a charity whose prime concern is the welfare of the older person. It's that combined with good practice – no missed calls, no calling cards...”

So, although service user and provider views often conflicted on the issue of achieving reliability, there were one or two service user views that supported the optimistic assessments by home care managers.

6.2 Flexibility

Service users were also invited to discuss the importance of flexibility in their home care service.

It was clearly important to service users that they could ask for help with tasks beyond those on their care plan. This was most commonly the case among service users living alone. Not everyone felt they could ask for changes but if they could, the sorts of things they asked for was for washing to be hung on the line, for errands such as shopping or pension collection and for help filling out forms. “I have x (carer) in the morning, she’ll do anything I ask, she’s another diamond...” Other than help with extra tasks some service users felt able to ask for changes in the times their carers visit. Only two people felt they could or needed to do this and in each case it was so that their care could fit round day care or hospital appointments.

However, the most common experience was service users who felt they could but did not need to ask for changes. The explanations given were either that their needs were routinely met by their care plan or by their home carers volunteering any extra help. The majority of those interviewed were found to be in that situation and were very happy with it. Reporting her carers willingness to do anything at all, one service user commented, “she does everything I can’t do and I can’t do nothing...except lean on me elbows!”

However, not all service users felt they could ask for changes. Although they were few in number (three), their experiences are important. For example, one service user, living alone, would have liked her carers to do more jobs for her, especially wiping the inside of her windows and changing her net curtains. Although she asks her home carers to do those and other jobs they have told her they are not allowed to do them. She was clearly distressed about the situation and confused about what things her home carers are allowed to do. The spouse of another service user reported that she had not asked for changes since the supervisor had explicitly told her the carers would only deliver personal care. Although she would like to ask the carers to do odd jobs, she has the feeling that the carers’ time is very limited and consequently she doesn’t want to put them under any pressure. Another service

user who never asked for changes because she didn't want to "put upon the carers" echoed that feeling. However, her situation was more worrying. Not only was she unsure about what her carers were allowed to do, she felt she had never seen a care plan and did not know what her carers were supposed to do. These perceptions meant that service users felt they could not ask for any changes which related to tasks or timing of visits.

Flexibility of service

Having explored the possibilities of making changes to their care, service users were asked to rate their service in terms of its overall flexibility.

Table 3 shows that when over half those interviewed asked for extra help or different times, the changes were made. Seven out of the twenty people interviewed had never asked for changes due to a range of reasons; one had no need to ask, one did not know whether they could ask, two felt unable to ask and three felt they could but as yet had no need to. Although the table shows that no service users felt "the changes I asked for are never made", this does not reflect those individuals who had once been refused and had never asked again or those who felt they shouldn't "put upon" their carers.

Table 3: Flexibility of the service

	<i>Number</i>	<i>Percent</i>
The changes I ask for are <u>always</u> made	12	60
The changes I ask for are <u>sometimes</u> made	1	5
The changes I ask for are <u>never</u> made	0	0
I have <u>never asked</u> for any changes	7	35
Total	20	100

The provider perspective

The managers of the home care organisations were also invited to explore issues around the flexibility of the service they provide. Interestingly, the notion of flexibility did not mean the same thing to every manager. To some it meant their capacity to respond to service users'

fluctuating needs, “to have the ability to provide care when the client needs it – that we look at the care needs of our clients rather than at the work needs of our employees.” However, others felt ‘flexibility’ was something their service users ought to demonstrate. A quarter of those interviewed expressed the view captured by one manager; “We do wish clients would be more flexible, especially with 8am calls because everyone wants an 8am call. We can’t always provide an 8am call” and another, “that the service users have some appreciation of how difficult it is to provide their visits at exactly the time they want them...”

However, the managers did generally agree about what makes it difficult to provide a flexible service. Their views on this issue also concurred with the explanations service users had been given and they were mainly time pressures and prescriptive, inflexible care plans. Many managers were frustrated by uncompromising commissioning arrangements including unrealistic time allocations and in some cases, inappropriate needs assessments; “we always find that when we go out to assess a new client, their care needs, in terms of time, are very different to what the SDO says”. Almost all those interviewed complained about the inflexible nature of the SDO’s, which mean that if any changes need to be made, they are obliged to let social services know and, in some cases a new assessment will be carried out, “It’s very difficult to achieve flexibility because current contracts are task oriented” and “we’re not allowed to be flexible unfortunately a lot of the time cause we’re dictated to as to the times we have to do things”. Manager’s frustration about their inability to deliver that aspect of quality was evident, “it would be nice to be flexible if you were trusted to be flexible.”

However, it seems that the restrictions felt by managers are often not observed by home carers, and in some cases, managers were very well aware of this, “the carer and the client usually end up sorting it out between themselves – though that’s not really what social services want.” The views of the service users supported that suspicion as a higher proportion received help with extra tasks than the frustration of the managers would suggest. In several instances home carers were undertaking additional tasks at their own discretion. Although this is a positive outcome for service users the reality is that carers are doing work they are not being paid for.

6.3 Continuity

Respondents were invited to discuss the importance of having a regular carer, or where that was not possible, a team of regular carers. It was not an issue of great importance to all those interviewed. Just under half had specific views. Of those, opinion was weighted more toward those who preferred to have regular carers.

Some people were keen to have the same carers because they had become attached to them and felt they were like members of their own family. One service user had enjoyed the same carer for 11 years and become very close to her but she recognises that when the carer is ill or it's the weekend, it's not possible to keep the same one. Others also recognised that the volume of their care package meant that, at weekends, they would have to have other carers, "...then at the weekends I get the funny ones because the other ones have worked all week." Nevertheless, one or two users were less understanding and were unhappy when they didn't know their carer or didn't know who to expect, "When they are on holiday you never know who you're going to get and that's the trouble"

Some service users and their informal carers had reasons other than personal preference for why they needed the same care workers. One service user, living alone placed paramount importance on having regular carers because he was only partially sighted and had to get to know someone's voice because he cannot see their face. He found it unnerving to have to let complete strangers into his home. In another case, the wife of a service user explained the importance of having regular carers for her husbands' sake, "it's because of his mind...he has very poor short term memory so if there's a string of different carers he gets confused, it's not fair (on him)..."

However, some service users were happy to have a range of different carers and some were confident that even if they had different ones, they had always seen them before and they were never strangers. Those who were happy with different carers were only concerned that the people that came could do the job. One service user with a six-day package reported being able to see five different carers in a week, but he didn't mind, "just as long as they can cook!"

Continuity of the service

Service users were asked how they would rate their service in terms of continuity. Table 4 shows that almost all those interviewed “nearly always” saw the same care workers.

Although no one reported “always” seeing the same care workers, all those interviewed understood that it would be logistically impossible, to always see the same single carer. They appreciated that given the complexity of their care package, they couldn’t expect one carer to visit twice a day seven days a week. They also understood that when their carers were ill or on holiday they would have to have relief carers.

Table 4: Continuity of the service

	<i>Number</i>	<i>Percent</i>
Yes, I <u>always</u> see the same care workers	0	0
No, but I <u>nearly always</u> see the same care workers	19	95.0
No, I <u>hardly ever</u> see the same care workers	1	5.0
No, I <u>never</u> see the same care workers	0	0
Total	20	100.0

The provider perspective

When asked about issues around continuity, the home care managers recognised that, to some service users, it was crucial, “It’s very important to service users, if you need intimate personal care you’re not going to want a different person every day”. They supported the service user perspective that, continuity of care generally meant continuity of carers.

However, those who were interviewed underestimated service users’ capacity to appreciate that “One carer, seven days a week, four calls a day” was not possible, “we can’t promise what the service users want – no carer works seven days!” Home care managers instead sought to provide continuity in a *team* of carers. This supported most service user’s experiences that they had two, three or four regular carers, and that, overall, they were happy with the situation.

Invited to discuss the things that made it difficult to maintain continuity, the providers' views again concurred with the service users' explanations. They cited sick leave as being particularly problematic, because along with other personal emergencies, it could not be planned for. Furthermore, in the case of unauthorized absences it was difficult to provide cover by carers already known to the service user. The managers also referred to staff recruitment and retention problems to explain that with a small pool of carers it was very difficult to allocate carers to certain service users and maintain that arrangement.

Home care managers identified the strategies and practices they adopt in order to achieve as much continuity as possible. Many of them arranged their carers in teams that were attached to certain service users and this was in the hope that when a relief carer was needed it would be someone the service user knew. Other organisations reported methods of arranging rotas so that gaps could be identified well in advance and service users could be warned that someone other than their regular carer would visit. Some organisations also made introductory visits so that service users met their carers before they start receiving the service.

Although service users were unaware of the planning provisions made to ensure the continuity of their service, most of their views supported those of the providers that overall, they enjoyed a regular carer or team of carers and that they only very rarely received care from "strangers", "once or twice I've had strangers in but normally it's someone I know."

6.4 Communication

Communication was an important issue to many of the service users and it was intrinsically linked to both reliability and continuity. If carers were going to be late for a call, service users wanted to be informed, and similarly, if they were going to have a carer other than their regular one, many wanted advanced warning, "if they don't tell you when they're going to be late you'd end up hanging around and waiting for them." That was a view echoed by many service users who felt it was important that they should be kept informed if their carer was going to be held up. Those who had "get up" calls felt particularly strongly that they should be warned, "I don't want to be in my pyjamas all day!"

Communication by home care services

When asked to rate their home care company, there was a mix of opinion about their performance on the issue of communication. Table 5 shows that over half the service users

reported that their home care company kept them informed if their carer was going to be late, but five people were not always kept informed and three service users felt they never really knew what was going on.

However, some service users found it very difficult to answer the question. All of those interviewed understood the question to be about whether the supervisors and managers – “the office” – keep them informed and, they found it difficult to answer because in eight out of the 20 cases, they were kept informed by their carer, and never the organisation itself (table 5 below). In all of those cases, the carer undertook to keep the service user informed about any changes to their care plan, whether their service would be late or whether they would have a different carer.

Table 5: Communication

	<i>Kept informed by carer</i>	<i>Kept informed by HC organisation</i>	<i>Not kept informed</i>	<i>Total</i>
They <u>always</u> phone ahead to warn me when the carers going to be late	7	5	0	12
They <u>don't always</u> phone me when the carers going to be late	1	3	1	5
I <u>never</u> really know what's going on	0	0	3	3
Total	8	8	4	20

Although five of those that the carer kept informed were content with this situation, three people felt it wasn't an appropriate way for the company to operate. They felt strongly that their home care organisation had a responsibility to keep them better informed and were unimpressed with the level of communication, “the organisation needs organising! If I ring up to ask who my carer is when my normal ones away they never know where they are.”

Some were only kept informed in certain circumstances. Although their carers kept them informed if they were going to be late, people were less commonly kept informed if they should expect a different carer. This was particularly significant in the case of the partially

sighted service user who was one of the three to “never really know what’s going on.” The other two who felt they were never kept informed were both housebound and living alone.

The provider perspective

Invited to discuss the issue of communication, home care managers recognized its importance. To some, it was a central element of their service, “Communication is the be all and end all of what we do because that’s where we start off and that’s where we finish.”

All of the home care managers who were interviewed recognized how crucial it was that they keep their service users informed about any changes to their care packages. However, over half of them felt that communication was important at more than one level. In addition to keeping the service user informed, the providers were determined that there should be good communication between care managers and providers and between home care managers and home carers and that in both cases communication should be two way. They felt that care managers have a responsibility to properly communicate the service users needs and that they themselves have a responsibility to keep social services informed of any changes to the client’s health. They also felt that carers ought to keep them informed about the service users’ fluctuating health and needs and that, as managers, they had to properly communicate with carers to inform them whenever there needs to be a change to normal routine, “it’s got to be key to it all.”

One or two managers also felt communication between carers and service users was important. A small number were resigned to the fact that communication at that level was actually the most common channel. However, some felt this was problematic;

“The carers tend to communicate directly with the service users so sometimes we get missed out of the loop – but because of the confusion sometimes the client gets missed out of the loop and they’re the last to know or they only know after the event.”

Although a small number of managers recognized that communication with the client was mainly through the carer, this did not account for the eight out of 20 service users who reported that it was their carer alone who kept them informed. Furthermore, the managers’ accounts of their practices to maintain sound communication did not support four cases

where service users were not kept informed at all and the three who felt they “never really know what’s going on.” For example, the provider of one service user who felt that she was never kept informed, claimed to phone clients a week in advance about changes to their service, and claimed that carers phone the office whenever they’ve been held up so that the client can be informed. However, the manager of that provider organization did concede that it was sometimes impossible to maintain that level of communication, “sometimes it’s just so hectic, so busy, and we’re not able to keep the client informed as much we’d like to.”

Overall, home care managers recognized the overriding importance of sound communication. They felt it was key to the smooth running of their organization and to the proper delivery of care. Most managers reported mechanisms in place that included out of hours contact, 24-hour pager systems, and organized forward planning but unfortunately these were not reflected in service users’ experiences. Twelve out of the 20 users interviewed were either kept informed by their carer, and not “the office”, or they were not kept informed at all.

6.5 Trustworthiness

During the pilot stage interviews when service users were invited to talk generally about the good and poor aspects of their home care several raised the issue of the trustworthiness of their carers. Therefore, during the remaining interviews service users were invited to talk specifically about the issue of trustworthiness. They talked about its definition, it’s importance and the level of trust they had in their own carers.

The issue of trustworthiness was important and relevant to all but three of those interviewed. However, those three were interviewed during the pilot stage and were therefore not questioned specifically about the issue. As with all other respondents it is likely that if asked, those pilot interviewees would have attached as much importance to trustworthiness as everyone else.

The term ‘trustworthy’ did not mean the same thing to every service user. Just over half those asked felt it was about honesty. They wanted to feel that they could let carers into their homes with the confidence that they wouldn’t take anything or interfere with their personal possessions. On the other hand, two people felt that trustworthiness was about being able to tell their carers anything and know the information wouldn’t be repeated. Out of the 17 people who gave their definition of ‘trustworthy’, four felt it was a combination of honesty

and confidentiality. The spouse of one service user had a very different view of 'trustworthiness' as she felt that it was more to do with trusting the carers to be able to look after her husband properly, "I need to be able to trust the carers to be strong enough to help him."

Trustworthiness of home carers

Having explored their definitions of the term, service users were asked to rate the level of trustworthiness among their home carers. Of the 14 asked to rate their carers in terms of trustworthiness only two voiced any reservation and felt they could trust most, but not all of their carers. None of those interviewed felt they couldn't trust any of their carers.

Although the results reflect well on the provider organizations, they do disguise the fact that some service users had experienced problems in the past that had since been resolved. There were only a small number of reported incidents but the most serious ones were recounted by the two people who understandably felt that they could trust most but not all their carers.

One service user who was partially sighted had to let a carer into his home who he had never met before. He was unnerved by the situation but felt he had no choice but to let her in to provide his care. During her visit the carer manoeuvred herself behind the service user's chair, out of his field of vision and took his pension from his sideboard. The service user only later realized what had happened and although she never visited again, no action could be brought against the carer because of a lack of evidence. In the second instance a broken confidence caused an argument and bad feeling among the service user's neighbours.

Although the service user confronted her carer with the evidence and explained the trouble it had caused she still did not feel that she could ever trust her carer again.

Another service user felt that it was more the case that when they talk about other service users his carers have to trust him, "to tell you the truth dear, they tell me things more than I tell them...enough said!" Although in this case the service user did not identify the carer as untrustworthy it was clear that his carers were passing on information about other service users.

6.6 Staff attitudes

It was identified above that this was the factor most commonly cited by users as crucial to a high quality service. Everybody felt that their carers should have the right attitudes and had views about what those attitudes should be. Attitudes cited included respect, friendliness, cheerfulness and understanding. In order to explore what attitudes were seen key to a quality service, users were asked to identify the three most important ones. The three attitudes most commonly cited as important were being ‘obliging’, ‘friendly’, and ‘understanding’. However, other common views were that carers should be, ‘happy go lucky’, ‘jovial’ and that they should treat people with respect.

Being obliging was identified by 19 of the 20 users and ‘friendliness’ was cited by all but two service users as being an important carer attitude. People wanted to feel at ease and at home with their carers and those who felt like their carers were “one of the family” were generally very happy with their service delivery.

‘Understanding’ was mentioned by half of those interviewed as being an important aspect of staff attitudes. Service users value carers who understand them and their situation. It is important that they know what service users are capable of and are patient about the things they have difficulty with.

Closely related to “friendliness”, was the disposition of the carer, whether they’re happy, and in a lot of cases, whether they’re “jovial”. “Happy go lucky” and “jovial” were together, cited 13 times and their importance was clear and captured by one service users’ spouse who said:

“You don’t want someone coming in like a dying duck in a thunderstorm...we want someone that’s cheerful otherwise you can end up feeling down yourself!”

Although mentioned less frequently, respect was very important to those who identified this aspect of staff attitude. One service user, who had lost the use of a leg following a stroke, was determined that his carers should treat him with respect,

“Really and truly, I am disabled but some people talk to you as though you are a child – and that matters to me, to have a bit of dignity...I might be disabled but I’m not mentally disabled or anything like that.”

Both the service user and his wife felt that it was important that carers didn’t talk over him, for example, “does he want this? Is he alright? How is he? He’s looking well.”

Home care staff attitudes

Once they had explained the importance of attitudes and general disposition, service users then rated their service in terms of the overall attitudes of their carers. Three quarters of those interviewed were happy with the way all their carers treated them (see table 6). Of the five who had reservations, most had experienced a problem with one of their carers in the past. Those problems ranged from betrayals of trust to carers incompetent at certain tasks, especially cooking. Although not strictly staff attitudes these were the type of factors that respondents took into consideration when asked this question.

Home carers of the services being received were rated highly on the areas of importance that service users had originally referred to. Reflecting on her carer’s disposition, one service user felt, “she makes my day when she comes!” Another service user gave an overwhelming endorsement of the attitudes of his carers who are obliging, friendly and “happy go lucky”;

“I have x (carer’s name) in the morning, she’ll do anything I ask, she’s another diamond is x...I have y (carer’s name) at lunch time, she’s wonderful, in fact I think I’m in love with her!...and then there’s z (carer’s name) at 5pm and she’s a dream as well...”

Table 6: Staff attitudes

	<i>Number</i>	<i>Percent</i>
I am happy with the way <u>all</u> my carers treat me	15	75.0
I am happy with the way <u>most</u> of my carers treat me	5	25.0
I am only happy with the way <u>some</u> of my carers treat me	0	0
I am <u>not</u> happy with the way <u>any</u> of my carers treat me	0	0
Total	20	100.0

A number of service users felt that their carers were “like one of the family”. They clearly had the understanding, friendliness and respect to make the service users happy and comfortable. One service user reported, “I’m always quite at home with them...they’re just like one of my daughters.” And another reflected,

“They treat me as a friend, not just as someone they’re caring for...at Christmas and on my birthday they always make sure I have things, and on mother’s day there’s always a bunch of flowers...they’re family to me.”

Service users cited very few examples of poor staff attitudes. However, one man explained that one of his carers was the very opposite of obliging and certainly wasn’t friendly or jovial, “if she can do the job in five minutes she will...you don’t have time to talk to her much before she’s gone.”

Provider views

Home care managers concurred with users’ definitions of staff attitudes and importantly, the things which managers sought to deliver were the attitudes that service users most valued. For example, providers were determined that their carers should deliver the service with respect, care and sympathy. They recognised the need for their carers to be sensitive and understanding and felt that carers should be mindful of always doing and saying the right

thing, “anything they do or say should not harm a client in any way, and anything they *don't* do or say should not harm a client in any way.”

Many managers felt that the carer’s attitude was central to the delivery of care, and some even felt it was the most important quality aspect, “even if the carer does their job properly, does what they’re supposed to do, if they do it with a bad attitude they have just ruined everything.” The same manager placed paramount importance on the issue of delivering care with dignity and respect, a view, which concurs with that of some service users. The manager reported,

“I tell them, ‘Always treat elderly people with respect...why? Because being old is a blessing...No matter whether you are rich or poor, being old is a great achievement.’”

One aspect of carers’ attitudes that managers raised was the value of carers who are motivated by care and not solely by economics. Managers were concerned that where the latter was the case, it would be obvious in the carer’s attitude and apparent to the service user. One manager reflected, “you get carers who are really, really caring and those that are just doing it for the job – that’s where the difference in attitude is.” And another felt that, “Whether they actually do the job because it’s a vocation or whether they do the job to pay the bills – that attitude can come across.” Although service users didn’t allude to those issues when they were considering the notion of staff attitudes, the caring motivation became significant when they later considered what made their carers, ‘good’ or ‘poor’ carers (see section 6.7).

Home care managers also reflected on what made it possible to find and maintain those qualities in their carers. The main practices that managers employed were induction training that emphasized respect and dignity in care, ongoing supervision, and monitoring of standards. One manager outlined her company’s practices which was the same as many others,

“We send questionnaires to clients and they give us feedback on what carers are doing, what they’re not doing, what they’re saying, what they’re not

saying...if there's an issue we bring the girls in straight away and deal with it."

6.7 Knowledge and skills

The skills and knowledge that their carers demonstrated were clearly important to all service users. However it was also an important issue for the informal carers who participated in the interview process and their reasoning was different to those the service users raised themselves. They were less concerned with demonstrable skills like moving and handling, personal care tasks or domestic help and more with home carers' initiative and professional awareness. The wife of one of the service users felt, "it's about keeping an eye on him and knowing by looking at him and talking to him whether or not he looks well." The wife of another service user agreed, "it's important that the carers keep an eye on his physical condition and can spot if there's something amiss – if he doesn't look well..."

For the home carers to have this sort of awareness they clearly need to have a good existing knowledge of the service user. Some service users identified the importance of their carers having knowledge about them and about the way they liked to have either personal or domestic tasks done. Some felt that knowledge, rather than skill was the critical aspect and appreciated the carers who knew them well, "they know me inside out I think!"

However, many service users did not judge their carers' knowledge and skills in the way they would be commonly defined by training methods and standards. Almost all service users made a clear distinction between that concept and their own which prioritised the 'caring motivation'. To many it was simple; if their carers *care* they are good carers, if they don't then they are poor carers. The normal notion of skills and knowledge was much less significant. For example, answering the question 'what makes them good carers?', one service user responded, "because they're in the right work, they really care for people...they're not just doing a job, they really care." This opinion supported many home care managers' views about staff attitudes. However, to service users; it was the quality on which they judged the overall performance of their carers.

One service user went further than others in his reflection on skills and knowledge and the caring motivation. He even asserted that carers did not need skills, and that all that qualified

them was having a “human approach”. Although he captured most people’s views about the centrality of ‘care’, his represented a more fundamental view;

“Quite frankly, there’s not a skill attached to it really, it’s women who can cook and wash up and help you dress and undress, really, that’s all they have to do – there’s not a lot of skill attached to it. You could say it’s more or less an ability to do that. Skill is different.”

And he continued, “nurses have skill, they have to sit an exam...a carer doesn’t have a skill, they just have a human approach, be kind and happy...”

Although his was a rather extreme view, it did also allude to another perspective held by service users that the caring motivation was something people, particularly women had acquired through life experience. For example, another service user felt, “the older ones have the skills, they’re mothers and they know how to cook, the younger ones need teaching.”

Skills and knowledge of home carers

Table 7 shows that every service user felt that most or all their carers were skilled. This does reflect well on the provider organisations, but it is important to remember that most people were actually judging the ‘caring motivation’ or the human approach of their carers. Only four service users attributed their carers’ good performance to their training, and three to their professional experience. Another 10 attributed their carer’s skills and knowledge to either their personal experience or their motivation for their work.

Table 7: Skills and knowledge

	<i>Number</i>	<i>Percent</i>
My carers <u>are good</u> at what they do	11	55.0
<u>Mostly</u> my carers <u>are good</u> at what they do	9	45.0
<u>Mostly</u> my carers are <u>not good</u> at what they do	0	0
My carers <u>are not good</u> at what they do	0	0
Total	20	100.0

The provider perspective

Home care managers' views about skills and knowledge were different to those expressed by service users. Although some felt that caring skills were to some extent "instinctive", all those interviewed felt that skills and knowledge were those things which are instilled, maintained and assessed through induction and training, "Its competence, it's being properly trained in delivering the care which you say you're there to deliver." Another manager agreed that to have appropriate skills and knowledge carers should "have proper induction and training." He also felt it was important "That they are kept up to date with new techniques – for example developments in moving and handling."

Many home care managers also recognised the importance of having specific knowledge about service users and their needs, "it's also about the carers knowledge of the individual service user." A small number of managers reported that team leaders make visits to service users before they start receiving the service and they then pass on all relevant personal information or preferences to those delivering the care. This concurs with the priorities of some informal carers and some service users who valued the knowledge their carers had built up about them.

Although only four service users felt that their carer's ability was due to their training, all the home care managers identified that their organisations followed their own and national guidelines about training and skill standards. Agencies provided a core of induction, moving and handling, and first aid. As well as induction and subsequent courses, home care managers were confident that their carers' regular reviews served to identify any gaps in training that could be quickly addressed.

However, care managers were also invited to discuss any barriers they faced to maintaining a properly skilled workforce. At the time of interview they were all concerned with the demands of the impending Care Standards on training. The two main barriers they had to contend with were reluctant care staff and financial constraints.

The most commonly cited issue was financial constraints. Many had already decided on in-house training as the cheapest option. However, most still faced problems. One home care manager was clearly worried about their inability to finance training, especially in the face of Care Standards, "There are definitely costs implications for training. NVQ's are very

expensive, this is a big problem and at the moment we have no carers working toward them.” Not every manager faced the same degree of concern. However, most agreed that the cause of the problem was the restrictive prices the authority pay for their contracts and they agreed about the consequential effects of the situation,

“x’s (the local authority) prices allow for only minimal training at the moment. This is a restriction in trying to provide quality of care. To achieve and maintain quality we ought to be able to pay the carers more money. But, we have to train them so the restrictions hit the wages.”

The financial restrictions on training also heightened the practical problem that managers faced in arranging courses around carers’ shifts and in most cases, finding the money to pay carers to attend training sessions.

The other barrier to providing adequate training was carers’ reluctance to take up courses and follow training programmes cited by two managers. There were carers who had been in the profession for a long time who did not see the sense in taking exams in things they had been doing well for years, “Some of the older ones really can’t be bothered with training. It’s a headache chasing them, reminding them and making them come in for training.” However, some younger carers were also reluctant because they had chosen the profession thinking they had endured their last exam at school,

“Sometimes its the carers motivations that make it difficult. Some of them are just looking for a bit of pocket money and whether they actually take in all the training and knowledge we give them is debatable. Some of them didn’t come into this work to learn and train.”

6.8 Choice of carer

Having explored all the quality aspects raised by the interviews, service users were invited to discuss any other issues, which they felt affected the quality of their service. The one overriding concern, which they raised, was the choice of their carer.

18 of the 20 service users were asked specifically whether they had a preferred carer type. Only three people had no preference at all and were only concerned that their carers

should be good at their job. However, nine people stipulated that they wanted their care delivered by a mature woman and six stipulated a preference for a woman of any age. The preference for a female carer centred on the perception of women as “natural carers” and this is reflected in the comment of one service user who felt, “women have got a better, more humane, more caring way...”

The nine who wanted only mature women generally equated maturity with experience and skills. The notion of dignity was also intrinsic to most people’s preference for mature female carers, “I think in carers when you’re old, you don’t want young girls around you...middle aged women have had a family and they know the business of looking after people...”

One or two service users expressed a preference for carers of their own ethnic origin, in all cases, white British carers. Despite the fact that her views might be unpalatable to some, one service user did raise the issue of whether they are given any choice in the matter of their carer,

“I’m not a racist...(but) I do feel that before they send anybody coloured into a house they should ask if you mind...a lot of people my age are very colour prejudice and I just think that it’s a bad thing to send in coloured people without asking if it’s alright...I know that you hope that in this society that there’s not going to be this colour prejudice but it’s there...”

7. Future developments

Before introducing changes in commissioning and care provision it is important to have an understanding of user views. The proposed change of emphasis to “enabling” in home care could well challenge user perspectives of the role of the service and meet resistance in practice. It is also important to identify whether service users have views about proposed changes to commissioning arrangements or indeed views about how services are currently commissioned. Service users were invited to discuss these issues and provider managers consulted about their views on the upcoming contract relet and the related issue of their preferred contract types.

7.1 User attitudes to independence

Although most service users felt their home carers tried to promote their independence, three quarters believed that the role of domiciliary care was “to do things *for*” them. Only three people reported that their home carers did things *with* them. Even though they represented a small proportion of those interviewed, they were happy with the independence their carers encouraged, “I don’t want pampering because that don’t do me any good. If I give in I’ve had it...I’ve got to get up and get on with it.” However, with three quarters of all respondents feeling that the role of their home care is to do “for” and not “with” them this would suggest that a sea change in opinion is required before service users are persuaded about the virtue of the ‘enabling’ ethos.

A small number of service users valued the independence home care gave them from their otherwise constant dependence on their spouse. In particular, two service users identified the respite benefits intrinsic to their care. One reflected,

“Although I’m getting stronger, we still need them for x’s sake (service users’ wife) because, I mean, it’s a tiring business for her by herself...she couldn’t do it all the time – you’ve got to remember, I’m 73 and she’s 74, she does get shattered...”

His wife agreed,

“...it’s quite hard work, I’m not young myself, so we’ve found they’ve (the carers) been a big help.”

A small number of those interviewed also recognised the independence home care gave them at the most basic level. Where home care had been introduced following hospital discharge, they realised that the alternative to care at home was care *in* a home. For both service users and carers, that was an unattractive alternative. One service user had been offered residential care at the time of his latest hospital discharge. However, he was adamant that he wanted to remain in his own home so, at a case conference, he was told that dependent on his receiving home care and meals on wheels, he could stay at home. His relief was clear, “Having home care is the only way I could keep my independence!”

Although some service users and their carers recognise the benefit of home carers who strive to stimulate independence, those people were in the minority. One home care manager reflected on the significant change in mindset needed to introduce and implement the ‘enabling ethos’:

“x (the local authority) have some good ideas about enabling and so on but it’s going to take a lot of time – people are used to having things done for them and now they have to do them themselves...it’s not what they’re used to”

7.2 User attitudes to commissioning arrangements

In the light of the authority’s plans for changes to current commissioning arrangements, service users were invited to give their opinions about who they think ought to make decisions about the nature of the care they receive. Fifteen service users were asked whether they would prefer their care manager or their home care provider to take the decision about aspects of care they would receive. Of those, five felt their home care organization was best placed to make those decisions, four felt that their social worker should be making those decisions, four had other ideas and three did not know.

Those who felt their home care provider should make their care decisions generally believed they were best placed to understand people’s needs and know how to meet them:

“It would be better if the home care organization decide because they can see what’s going on in people’s homes and lives. They could arrange what they provide according to the changes they see in the people they care for”

“they (home care provider) are better placed to judge what people need. They’re in the person’s house and can observe changes on a day to day basis and will know what the person needs.”

This perspective supports the view given by one provider who felt that the nature of current commissioning arrangements only served to frustrate their attempt to provide a flexible and responsive service (see section 6.2 above).

However, four service users felt strongly that commissioning decisions should remain entirely with their social worker. That view was generally based on the notion that social services represented an impartial authority that would always maintain service users' interests. Most of the people who held those views had experienced problems with their provider organization and felt that in those situations, social services should act on their behalf. For example, one service user had previously asked her provider to change her carer when she became concerned about the carers' attitude and ability. Nothing at all was done and the home care manager "had all manner of excuses why they couldn't (change the carer)". She felt in those situations social services should be able to act on service users' behalf and resolve the issue for them. Another service user felt even more strongly that his social worker should make sure he gets all the care he needs because, "the home care organization have no right to tell me what I can and cannot have..."

One service user who agreed that social services should maintain their commissioning responsibilities feared that otherwise, the provider organization would hold too much control. He was also suspicious about the authority's motivation for change, "Are x (the local authority) council just trying to shift the job onto someone else?"

One service user suggested:

"It would be good if social services decide what people need then after three weeks of providing it the home care organization reports back to social services and tells them whether those things are working and if not, what else should or should not be provided"

7.3 Provider attitudes to contract type

The type of contracts the providers held with the local authority varied little and all but one currently held what managers referred to as "spot contracts" (or, 'call off contracts', where prices are agreed in advance and the service to be delivered is agreed on a case by case basis). However, only half of those stated that these spot contracts would be their preferred type, the other half opting for so called "guaranteed hours" (a guaranteed level of service is purchased). The main argument supporting a guaranteed hours contract was that it would allow for better forward planning because the agencies would know in advance what work they would have. However, those who supported guaranteed hours did so on the condition

that there would be sufficient hours and that those hours would be guaranteed. They felt that spot contracts provided them with little opportunity to forward plan and although the business was growing, it was difficult, with spot contracts, to manage staffing and other aspects of business. However, the proponents of spot contracts favoured their flexibility and the fact that they wouldn't *have* to take on work. One provider linked it to concerns over quality as they pointed out that they would only need to take on work when they felt able to deliver care with quality, and wouldn't be forced to take on work when they were already over stretched.

Of the 12 providers interviewed, all except two reported being on the local authority's preferred provider list. However, there were reservations about that status. Although they enjoyed the status, one manager voiced a concern about the continuing credentials of other agencies on the list and worried on behalf of service users that the local authority does little to monitor their preferred providers. A manager of another home care organisation speculated that although they enjoy a position on the preferred provider list, they must be right at the bottom of it, as they currently have no work commissioned by the council, and he added, "I don't even think they know where we are!"

Other more general concerns were raised about the level of monitoring by the study council. The main concern was about the performance of other providers and for the well being of service users. All providers were content with their own quality performance but were concerned that social services weren't doing enough to monitor the quality of all provider organisations, "monitoring is carried out once in three years...it's ok for us but you have to think about the providers who are getting away without giving quality care." And "we're satisfied because it means no interference but it's not good from a client point of view in terms of monitoring quality."

There was also some bad feeling generated by the fact that the only contact social services had with providers about individual contracts was when they had to follow up problems, "the only communication about contracts occur when we have fallen over."

Home care managers were also invited to discuss their concerns about local authority fee levels. An overwhelming majority, 10 of the 12 interviewed, reported that the fees the authority paid were inadequate, falling well short of covering costs. Home care managers agreed that the two areas which were affected were training and wage levels and that one is

usually compromised for the sake of the other. In the face of the impending Care Standards, managers' concerns were clear,

“Local authority fees do not cover all costs per head, they fall short by a long way. The short fall rests on training. At the last tender, our company did not have team leaders or senior carers (who are paid more) or NVQ's to finance. There are many requirements from the Care Standards Act and they all have serious cost implications.”

In the context of the continuing recruitment and retention crisis in social care, managers expressed their concerns about the impact of low fee levels on carers wage levels. One manager pointed out that in the new contract, he would have to charge social services more per head so that he can increase his carers' pay in an attempt to retain them.

However, some managers were sceptical about whether these issues would be recognised by social services and reflected in the fees they will accept in the new tendering process.

“Things should be better with the upcoming tender but x (the local authority) are going to cap the figure (the fee). Hopefully they'll take into account things like training, after all, we can't provide quality care if we have to cut corners.”

8. Implications for the local authority

Although the samples were small, users and providers reflected a wide range of circumstances. Users were mostly receiving high levels of homecare, and had usually been receiving services for a number of years. As such they represented considerable experience in using home care services. Overall it is reasonable to conclude that their views and experiences largely reflect those of users of home care services in the authority.

Of the seven key aspects of quality; staff attitudes, reliability, and flexibility were of key concern to service users, identified most frequently when first asked about the aspects of service quality that was important to them.

8.1 Commissioning for quality

The home carers themselves personify the services for users. Probably for this reason it was clear in the discussions that staff attitudes were sometimes taken to encompass other aspects of quality of the service flexibility, trustworthiness and competence. However, personal aspects of the carers such as friendliness and cheerfulness were clearly very important for people very dependent on their (usually) daily visits. With few exceptions users were very happy with the attitudes of their carers. However, as providers made clear, these are difficult qualities to ensure as a provider, and even more so as part of the commissioning process. Recruitment policies, training and pay clearly have a role to play in the attitudes of staff and these are likely to be affected by the prices paid and types of contract negotiated.

Timing of visits and reliability were crucial aspects of quality for about half the users interviewed. These aspects of the service were important for generating outcomes such as control over daily life and aspects of health such as diabetes. However, for half the sample timing of visits was much less important. The issues raised in discussion suggested that it was the tasks to be undertaken together with the attitudes of the individual user that determine the importance of timing and reliability. Providers identified the logistical problems associated with a lot of people needing to be got up in the morning at a similar time. It is clearly important as part of the assessment process and setting up the package of care that users' preferences are identified and taken into consideration in the way services are delivered.

There was some disparity between the degree to which providers and users felt the services provided were reliable, although users were generally understanding about the problems that arose so appeared to under-report their experiences in the more structured question. The disparity in user and provider perceptions was also evident for communication, which is critically linked to the reliability of the service. Providers clearly felt that they were much better at communicating about changes in timing and carers than users reported experiencing. Much of the communication appeared to be dependent on the home carers themselves, not something that users always felt was appropriate. Providers also emphasised communication between those commissioning and provider organisations. In all areas of communication there appeared to be room for improvement.

Ensuring flexibility in service provision is a difficult area while current policies and practice are aimed both at targeting services primarily on personal care needs and reflecting user views and preferences. Experience of flexibility of the home care service tended to be very much at the level of the individual carer and her attitude to the rules and doing tasks in her own time, resulting in inequitable service receipt by service users and, arguably, exploitation of home carers. Providers saw themselves as tied into the care plan so having little scope to offer a flexible service. Whatever system is put in place to allow more flexibility on the part of the provider, there will always be tasks (such as certain domestic tasks and shopping) that it is not intended for the contract to cover. If problems of inequity and the potential for exploitation are not to persist the local authority has to be clear how these needs are to be met where informal sources of assistance do not exist. Clarity is needed at all levels both about who provides and who meets the cost.

Although service users tended to prefer having the same home carers, the issue of continuity was only of critical importance for a few. This was linked to their particular circumstances and to issues of trust and communication. In terms of commissioning care this issue appears best addressed at ensuring that preferences and specific concerns of the user are established when the care plan is being agreed.

Users and providers interpreted skills and knowledge of home carers differently. Users tended to rather underplay the skills involved and tended to see these as associated with motivation and the characteristics of mature women. Knowledge of their circumstances was important and there was an acknowledgement of the importance of the monitoring role of the

home carer. The provider perspective was dominated by concerns about cost implications of the training requirements of the new Care Standards. They saw a clear trade-off between training and wages, as for the most part they do not feel that current prices paid cover their costs. If this were to work through in practice, potentially those prepared to train will lose their workers to those prepared to pay higher wages. Moreover, undue downward pressure on costs will clearly impact recruitment and retention, which in turn, affects other quality issues such as reliability and continuity. These types of problems are already being experienced in the care home industry, resulting in home closures (Netten et al., 2002).

8.2 Home care as an enabling service

As would be expected only a minority of users had experienced a reduction in home care services. Similarly a minority felt the service as it currently stands did things with them rather than for them. It is well established that older people define independence in many different ways, depending primarily on their circumstances (Hayden et al., 1999). For the most part the role of the service in promoting their independence is primarily about enabling them to remain in their own homes and home care services do this by doing things *for* them.

These results suggest that there may be some resistance to services that aim to be enabling. However it is more likely that the policy will be problematic to implement in practice because it usually takes longer to do things with people than for them. There is clearly a lot of time pressure under the existing arrangements. In any cost limited package that allows capacity for carers to spend time encouraging people to do things for themselves there will be pressure from users to get other tasks done, including those tasks not officially part of the package.

8.3 Commissioning arrangements and contracts

Users opinions were generally informed by their view of which party was best placed to make decisions about their needs. However, whatever their views service users generally wanted social services to maintain a role in the care process. As an independent authority people felt their care manager should be able to uphold their interests and intervene whenever they experienced problems with their care package.

Providers would welcome a more active role in managing the care arrangements, and this would address some of their concerns over providing a flexible service. However, there are

concerns about whether the prices paid will cover all the costs that they are likely to incur if they are going to recruit and retain a well-motivated and skilled workforce. This is not just about the price it is also about expectations. With the dominant type of contract, spot or call-off, the provider bears all the risk. In such situations expectations are key to planning and ultimately service quality (Department of Health, 2001). Low fees and low expectations based on LAs commissioning arrangements in the past and anticipation of increased demands for quality in the future have been found to be predominant reasons for closures of care homes (Williams and Netten, 2002).

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